

WISCONSIN MEDICAID PRENATAL CARE COORDINATION PROGRAM PREGNANCY QUESTIONNAIRE

Instructions: Type or print clearly. Before completing this form, read the Prenatal Care Coordination Program Pregnancy Questionnaire Completion Instructions, HCF 1105A.

SECTION I — GENERAL INFORMATION			
1. Name — Recipient (Last, First, Middle Initial)		2. Date of Birth — Recipient	3. Age — Recipient
4. Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	5. Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian	<input type="checkbox"/> Black <input type="checkbox"/> Hawaiian / Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Other
6. Education (Indicate highest grade completed.) <input type="checkbox"/> Primary / Secondary (1-12) _____ <input type="checkbox"/> College (1-4 or 5+) _____		7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
8. Address — Recipient (Street, City, State, Zip Code)			9. County
10. Telephone Number — Recipient		11. Other Telephone Number — Recipient	
12. What is the best way to contact you? When is the best time to contact you?		13. Name and Telephone Number — Emergency Contact Person	
14. Name — Medical Provider or Clinic (Doctor, Nurse Practitioner, Midwife) <input type="checkbox"/> I do not have a medical provider.		15. Recipient Medicaid Identification Number	
16. How many times have you been to a dentist or dental clinic in the last two years?			
SECTION II — CURRENT PREGNANCY			
1. When is your baby due?		2. What was the date of your last menstrual period?	
3. If you could change the timing of this pregnancy, when would you want it? <input type="checkbox"/> Earlier <input type="checkbox"/> No change <input type="checkbox"/> Later <input type="checkbox"/> Not at all		4. When was your first medical appointment for prenatal care? (month / year) <input type="checkbox"/> I have not seen anyone yet. <input type="checkbox"/> I have an appointment set for . (MM/DD/YY)	
5. Your Weight Before Pregnancy Your Current Weight Your Height		6. Are you pregnant with more than one baby (Twins, Triplets)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Are you thinking about breastfeeding your baby? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided		8. Have you had a Human Immunodeficiency Virus (HIV) test during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Have you had any bleeding or cramping? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Are you receiving nutrition services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

To be completed by Health Professional
Lim Eng
A- <20
A- >39
E- H
R- AI, A, B, HPI, O
Educ<12
MS- S

Tim- L, NAA
PNC- 2,3,N

BMI- <19.8
BMI- ≥26.1

WIC- Y

Continued

SECTION III — PREGNANCY HISTORY (If this is a first pregnancy, skip to Section IV.)

1. How many times have you been pregnant before?	2. Number of Full-Term Babies	3. Number of Babies Born More Than Three Weeks Early
4. Number of Miscarriages or Other Pregnancy Losses at 20 or More Weeks	5. Number of Miscarriages or Other Pregnancy Losses Before 20 Weeks	6. Number of Living Children
7. Number of Babies Weighing Less Than 5½ Pounds at Birth	8. Number of Babies Weighing More Than Nine Pounds at Birth	9. Date Last Pregnancy Ended
10. Outcome of Last Pregnancy <input type="checkbox"/> Live Birth <input type="checkbox"/> Miscarriage / Other Loss		

PreT
Loss 20+
LBW
Int<12m

SECTION IV — CONCERNS

1. Do you have, or have you ever had, any of the following conditions? Check all that apply. <input type="checkbox"/> Asthma. <input type="checkbox"/> Chlamydia, gonorrhea, syphilis, or genital herpes. <input type="checkbox"/> Diabetes.	<input type="checkbox"/> High blood pressure. <input type="checkbox"/> Seizures / epilepsy. <input type="checkbox"/> Urinary tract infection. <input type="checkbox"/> Other illness, infection, or condition requiring medical care.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have dental pain or bleeding gums when you eat or brush your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Before pregnancy, did you smoke cigarettes? If Yes, indicate the average number of cigarettes smoked per day.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Since you have been pregnant, have you smoked cigarettes? If Yes, indicate the average number of cigarettes smoked per day.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does anyone in your household smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. In the three months before your current pregnancy, did you use any form of alcohol? If Yes, indicate the average number of drinks consumed per week.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Since you have been pregnant, have you used alcohol? If Yes, indicate the average number of drinks consumed per week.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. In the past year, have you used street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Have you ever been physically, sexually, emotionally, or verbally abused by your partner or someone close to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Do you feel unsafe where you live?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. During the past month, did you miss any meals, not eat when you were hungry, or use a food pantry because there was not enough food or money to buy food?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Have you had any housing problems in the past three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Do you have transportation, child care, or other problems that prevent you from keeping your health care or social services appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Have you had problems with depression or received counseling or medications for mental health concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. During the past month, have you had little interest in doing things, or have you been bothered by feeling down, depressed, or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. How do you rate your current stress level?	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	
17. How many people can you count on when you need help?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3+	

1- Y
2- Y
4- Y
7- Y
8- Y
9- Y
10- Y
11- Y
12- Y
13- Y
14- Y
15- Y
16- H
17- 0

Continued

SECTION IV — CONCERNS (Continued)

18. Which of these things worry you a lot? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Money problems. | <input type="checkbox"/> My relationship with my partner. |
| <input type="checkbox"/> My job. | <input type="checkbox"/> My partner did not want this pregnancy. |
| <input type="checkbox"/> My partner's job or unemployment. | <input type="checkbox"/> Labor and delivery. |
| <input type="checkbox"/> My partner's drinking or drug use. | <input type="checkbox"/> Caring for this baby. |
| <input type="checkbox"/> My own drinking or drug use. | <input type="checkbox"/> Caring for my other children. |
| <input type="checkbox"/> My partner is in jail. | <input type="checkbox"/> Other . |

19. What worries you the most?

20. What do you do to deal with your problems?

21. Who can you count on for help with everyday activities, such as child care, meals, laundry, or transportation?

22. What topics would you like to learn more about? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Baby's growth and development. | <input type="checkbox"/> Labor and delivery. |
| <input type="checkbox"/> Breastfeeding. | <input type="checkbox"/> Managing the discomforts of pregnancy. |
| <input type="checkbox"/> Caring for your newborn. | <input type="checkbox"/> Nutrition during pregnancy. |
| <input type="checkbox"/> Family planning / birth control. | <input type="checkbox"/> Managing stress. |
| <input type="checkbox"/> Getting health care for you and your baby. | <input type="checkbox"/> Other . |
| <input type="checkbox"/> How to stop smoking. | |
| <input type="checkbox"/> Effects of alcohol on mother and baby's health. | |

23. Additional Information

SECTION V — TO BE COMPLETED BY HEALTH PROFESSIONAL

Is the recipient eligible for Prenatal Care Coordination (PNCC) services?

- ☐ Yes, based on a number of factors or age .
- ☐ No.

SIGNATURE — Staff Completing Assessment

Date Signed

SIGNATURE — Qualified Health Professional (If Different from Above)

Date Signed
